POST- JOB OFFER MEDICAL QUESTIONNAIRE

Employee Name _____

Date of Birth ___/___/_____ (month/day/year)

1. Have you ever had or been treated for any of the following:

	YES	NO		YES	NO
Epilepsy	☐	☐	Head injury	☐	☐
Diabetes	☐	☐	Back injury/pain	☐	☐
Amputation of foot, leg, arm			Beck injury/pain	☐	☐
or hand	☐	☐	Shoulder injury/pain	☐	☐
Loss of sight of one or both			Arm/elbow injury	☐	☐
eyes or a partial loss of un-			Hand injury	☐	☐
corrected vision of more than			Hernia	☐	☐
75%	☐	☐	Knee injury	☐	☐
Cerebral palsy	☐	☐	Herniated/slipped disc	☐	☐
Multiple Sclerosis	☐	☐	Neck surgery	☐	☐
Parkinson's disease	☐	☐	Back surgery	☐	☐
Cardiovascular disorders	☐	☐	Tuberculosis	☐	☐
Carpal/cubital tunnel syndrome	☐	☐	Foot/ankle injury	☐	☐
Asthma	☐	☐	Hearing loss	☐	☐
Hemophilia	☐	☐	Sickle cell anemia	☐	☐
Joint pain	☐	☐	Cancer	☐	☐
Pulmonary disease	☐	☐	Headaches/dizziness	☐	☐
Any other pre-existing disease, condition or impairment which is permanent in nature, OR for which your doctor has indicated physical limitations/restrictions indicate below	☐	☐			

_____
_____

2. If you answered "yes" to any of the above in question one, then for <u>each</u> please:

   a. Identify the specific injury or condition and how it occurred:

_____

_____

_____

b. If the condition or injury resulted in surgery, state the type of surgery performed and list the impairment rating given from your physician (if applicable):

_____

_____

c. State whether you have physician imposed physical restrictions OR personally imposed physical restrictions as a result of the injury or condition, and what those restrictions are:

_____

_____

3. Do you now or have you ever had any disability or physical or mental condition which limits you in any way?

YES	NO
☐	☐

If yes, please explain:

_____

_____

4. Have you ever been turned down for any employment, medical, health or life insurance or military service because of your health or physical or mental condition?

YES	NO
☐	☐

If yes, please explain:

_____

_____

5. Are you now on any prescription medication?

YES	NO
☐	☐

If so, what medication(s)? _____

For what condition(s) was the medication(s) prescribed? _____

By completing this form, I am verifying that the above named company has already presented a conditional job offer to me and no questions in the medical questionnaire were asked of me by anyone prior to my job offer. I hereby affirm that the answers to questionnaire are truthful.

X_____ _____

Signature **Date**

THIS FORM MUST BE SIGNED AND DATED